

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
4 MONTHS

TO BE FILLED IN BY OFFICE STAFF:

Last Name		First Name		AHCCCS ID		D.O.B.		Age	
Primary Care Provider				Date of Examination		Health Plan Name			
Birth Wt.	Weight	Percentile		Height	Percentile	Head Circumference		Percentile	

TO BE FILLED IN BY PROVIDER

HISTORY	INITIAL/INTERVAL	
		F

Comments	T_____
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NUTRITIONAL ASSESSMENT [] Breast Feeding [] Formula (type) _____ P _____
Supplements: [] Fluoride [] Vitamins [] Iron [] Solids

SENSORY ASSESSMENT	Vision:	Within normal limits?	<input type="checkbox"/> Yes	<input type="checkbox"/> No, Refer	Songs	R _____
	Hearing:	Within normal limits?	<input type="checkbox"/> Yes	<input type="checkbox"/> No, Refer		

DEVELOPMENTAL ASSESSMENT Age appropriate? ☐ Yes ☐ No, Refer
☐ Yes ☐ No

Babbles and coos, when prone-holds head erect and raises body on hands, rolls over from prone to supine, grasps rattle, controls head well (If suspicious, do specific objective testing) Assessment Tool (name) _____

R _____

PHYSICAL EXAM

Are the following normal?

Yes No

Skin			
Head			
Eyes (red reflex)			
Ears (symmetrical)			
Nose			
Mouth/Throat			
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Hip Abduc.			
Extremities			
Spine			
Neuro			
Other			

LAB/SCREENING

Hct./Hgb.		
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COMMENTS, ASSESSMENT & PLAN

[illegible]

Follow-up needed? ☐ Yes ☐ No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? ☐ Yes ☐ No

Is there a current immunization record in the medical chart? ☐ Yes ☐ No

ANTICIPATORY GUIDANCE

<input type="checkbox"/> Injury prevention	<input type="checkbox"/> Sleep positioning
<input type="checkbox"/> Choking, aspiration	<input type="checkbox"/> Thumb sucking
<input type="checkbox"/> Teething	<input type="checkbox"/> Baby-proof home
<input type="checkbox"/> Solid foods	<input type="checkbox"/> Appropriate child care providers

REFERRALS

[] CRS
[] WIC
[] Specialty _____
[] Other _____

Next scheduled visit	Clinician Name	Clinician Signature
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Was this claim coded as an EPSDT Visit (HCFA-1500)? ☐ Yes ☐ No